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Authorization to Obtain/ Release Medical Records

Patient Name: _____ **Date of Birth:** _____

Telephone #: _____

Purpose of Release: _____

I hereby authorize North Point Physicians, LLC to: ☐ Obtain from ☐ Release to

Name: _____

Address: _____

City, State, Zip Code: _____

Telephone #: _____Fax #: _____

any information, including diagnosis and medical records of any treatment or examination rendered to me during the following time period:

☐ the past twelve (12) months, **OR**

☐ from the time period _____ to _____

☐ Other: _____

and to include any Federal and state protected information under Florida Statute 394.459 (9) Psychiatric information, Florida Statute 397.501, and 396.112 Drug and/or Alcohol Abuse Information, and Florida Statute 381.004 and FAC 10D-93.064 Human Immunodeficiency Virus test result (HIV testing, AIDS, and related conditions).

I understand and direct that this authorization remains in effect for a period of twelve (12) months or until I revoke it in writing. I hereby release the above named medical facility, practitioner, and its employees from any and all liability that may arise from the release of this information as I have directed.

Signature: _____ Date: _____
(Patient, Parent if minor, or Legal guardian)

Witness: _____

Rev. 11/13